Developmental Disabilities Division

Wyoming Department of Health

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CHILD

Home and Community Based Waiver Program

An Application Resource Guide to help individuals with Developmental Disabilities access Services through the Developmental Disabilities Division

July 2009

Developmental Disabilities Division
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Application Checklist

	Task	Date Received or Completed:
1.	Area Resource Specialist (ARS) is contacted by person/guardian, advocate or other agency representative requesting the waiver services.	
2.	Area Resource Specialist meets with person/guardian requesting waiver services	
3.	Person/guardian requesting waiver services completes application and sends to Developmental Disabilities Division (DDD). (If this has not already been done.)	
4.	Person/guardian requesting waiver services is given the Case Manager Selection form and choice list by the Area Resource Specialist.	
5.	Person/guardian requesting waiver services interviews Case Manager. The Area Resource Specialist can help with this process.	
6.	The Case Manager Selection form is completed by the Case Manager and the applicant and/or the legal entity and then sent to the local Area Resource Specialist.	
7.	The Case Manager will complete the Level of Care and send to the Waiver Specialist in Cheyenne for review of eligibility.	
8.	The Case Manager will assist family in gathering medical documentation if the applicant has a related condition. This will be made available to the psychologist and will be sent to the Division, along with the completed psychological evaluation.	
9.	Upon review and approval of the Level of Care by the Waiver Specialist, work with the Case Manager to make an appointment for the psychological evaluation. Date of appointment: _____ Name of licensed psychologist:	
10.	The psychological evaluation is completed. A licensed doctor of psychology must complete the psychological evaluation for this waiver application.	
11.	When the psychological evaluation is completed, the Case Manager completes the Inventory of Client and Agency Planning (ICAP) checklist and submits it and the psychological evaluation to the Division.	
12.	The ICAP is completed through Developmental Disabilities Division if the psychological evaluation indicates a diagnosis of mental retardation or a developmental disability.	
13.	Developmental Disabilities Division reviews for clinical eligibility. You will receive one of three letters: eligible, denial or waiting list. The Case Manager will receive a copy of this letter.	

14.	If a funding letter has been received, the Case Manager works with the family/applicant to make an appointment with Department of Family Services for financial eligibility. A copy of the Funding letter and a copy of the Level of Care must be submitted to the Department of Family Services during this appointment. The Plan of care cannot be approved until the Department of Family Services has determined financial eligibility.	
15.	The Area Resource Specialist will contact you to complete an initial IPC meeting training.	
16.	Interview potential providers for availability and compatibility.	
17.	The Case Manager will schedule a team meeting with the Area Resource Specialist, providers, family and anyone else you would like to invite, to develop the Individual Plan of Care	
18.	Start date of services.	

Introduction

(The underlined words can be found in the glossary at the end of this book)

The state of Wyoming provides services for children with developmental disabilities from a variety of agencies. All children with developmental disabilities are eligible for special education services, birth through 21. Department of Family Services may assist children and their families. Some children may qualify for programs such as Children with Special Health Needs or the Children's Mental Health waiver. Many children also receive services through the Developmental Disabilities Children's waiver and a very small minority may receive services through the Wyoming Life Resource Center, an ICF/MR institution.

- **What is the Developmental Disabilities Child Waiver?**

Waivers are programs that waive certain restrictions of the Wyoming State Medicaid Plan to allow the state to fund additional services not covered by the Medicaid state plan, in a person's local community. The goals of these services are to support you in your own community and to avoid the need for residential institutional care.

- **Where can I find information and forms required for applying for the Developmental Disabilities Child Waiver?**

Division Contact Information

Counties Served	Contact Information
Star Valley Area, Uinta, Lincoln, Kemmerer, Sweetwater,	307-789-0618
Fremont, Teton, Sublette	307-856-4648
Campbell, Crook, Sheridan, Johnson	307-684-7632
Converse, Natrona,	307-234-6439
Weston, Niobrara, Carbon, Albany, Platte, Goshen	307-534-4658
Laramie	307-777-3529
Big Horn, Hot Springs, Park, Washakie	307-527-4181
Statewide Contacts	
Deputy Administrator	307-777-8763
Adult Waiver Manager	307-777-5660
Children/ABI Manager	307-777-3321
Area Resource Specialist Manager	307-777-6775
Survey/Certification Manager	307-777-8761
OR	
307-777-7115 or 1-800-510-0280	

SAMPLE

APPLICATION FOR SERVICES: INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES OR ACQUIRED BRAIN INJURY

Date: _____

(Please check)
_____ Developmental Disabilities Adult Waiver
_____ Developmental Disabilities Child Waiver
_____ Acquired Brain Injury Adult Waiver

To: Division Personnel

Please consider this letter as a request to access services for approved services from the Developmental Disabilities Division, for an individual with the diagnosis of mental retardation, an acquired brain injury or a related condition.

Name of Person Needing Services:_____

SSN:_____ - _____ - _____ DOB:_____/_____/_____ Phone:_____

Physical Address:_____ Mailing Address:_____
_____ _____
City State Zip City State Zip

Emergency contact:
Name:_____ Address: _____
Phone:_____ _____

In which town do you want to receive services? _____

Are you currently using Developmental Disabilities Child Waiver services? YES ☐ NO ☐

Is this person currently in any type of inpatient facility, i.e. the Wyoming State Hospital, the Wyoming Life Resource Center, the Wyoming Behavioral Institute, a hospital, a nursing home, incarcerated, BOCES, etc.? YES ☐ NO ☐

Facility Name:_____ Anticipated Exit Date: _____

Please fill out the following section if the person above is under 18 years of age or the person above has a legal, court-appointed guardian (full or limited).

Name of Parent(s)/Legal Guardian(s): _____
Address: _____ Phone: _____

City:_____ State: _____ Zip: _____

Is this person a legal court-appointed guardian (full or limited)? **YES**☐ **NO** ☐

I am interested in the Wyoming Life Resource Center and would like more information. **YES**☐ **NO**☐

The signature of the person needing services is required. The parent may sign if the person is under 18 years of age or the legal guardian may sign, if one has been court appointed.

Signature:_____

For DD and ABI Waivers, please mail this form to:

Area Resource Specialist label

For questions about the DD and ABI Waivers, or local ARS phone number please call: 307-777-7115 or 800-510-0280

(DDD Revised: 11/01/2003, 11/17/05, 02/06, 05/06, 09/07, 07/09)

What happens after I send the application into Developmental Disabilities Division?

You will receive an Application Acknowledgement letter from the Developmental Disabilities Division. The next step is to choose a Case Manager and complete the "Case Manager Selection" form.

- **What is clinical eligibility?**

To be clinically eligible for the Child Waiver you must meet the following:
You must:

1. Be a United States Citizen or Department of Family Services approval for citizenship
2. Be a resident of Wyoming
3. Be under 21 years of age
4. Meet the Level of Care criteria
5. Have a diagnosis of mental retardation as determined by a licensed psychologist
   or
   Have a related condition as determined by a physician and functional limitations verified by a psychologist; and
6. Have an Inventory of Client and Agency Planning (ICAP) of an age adjusted service score equal to or less than 70;
7. An adaptive behavior quotient of .50 or below for children birth through age 5;
   or
8. An adaptive behavior quotient of .70 or below for individuals age 6 through age 20.

- **What is a related condition?**

A related condition is one that results in a severe, chronic disability affecting an individual which manifests itself before he or she reaches age twenty-two and that is attributable to cerebral palsy, seizure disorder, autism or any condition other than mental illness that is closely related to mental retardation and that requires similar services, as determined by a licensed psychologist or physician.

Choosing a Case Manager for Case Management Services

- **Do you have to choose a Case Manager?**

Yes! But you have the right to choose (informed choice) among any enrolled provider available on the Child Waiver program. It is your responsibility to set up interviews and select providers.

- **How do you choose?**

Your Area Resource Specialist (ARS) will give you a list of Case Managers who work in your area. The Case Manager is the first provider you will choose.

When you are going through the eligibility process, your Case Manger will be providing you with Targeted Case Management. The Case Manager should be checking with you, assisting you with the application process by helping you gather medical information if needed, initiating the psychological evaluation, and the Inventory for Client and Agency Planning (ICAP) Checklist. The case manager will also be helping you identify other services your child may qualify for while you are going through the eligibility process and if you are eligible but still waiting for services.

If you are eligible for waiver services, the Case Manager will be providing you with Case management services. The Case manager is responsible for the plan of care, home visits, scheduling meetings, completing paperwork that is both accurate and timely and monitoring services. The Case Manager is required to visit your home at least once a month. It is important you choose a Case Manager who will meet your needs.

- When you interview a potential Case Manager, here are some ideas of questions you may want to ask. You may ask the Case Manager any questions that you feel are important.

Do you have any openings?

If I were to pick you as my case manager how soon would we be able to start this process?

How much case management experience do you have?

Do you have experience working with persons with disabilities? How much?

How much time per week do you typically spend doing case management?

Will you be able to meet me at times that are convenient to me?

Do you have specific office hours?

Discuss what professionalism means to you?

Do you communicate well?

Are you willing to take time to listen to me?

If a funding opportunity is made available to me today would you be available to provide Case management services?

Date	Case Manager Contacted	Notes

- **How often can you change providers?**

You can change your Case Manager, when scheduling your 6 month or annual IPC meeting.
For a more complete description of the procedure please contact your local Area Resource Specialist. [refer to page 6]

If you would like to change other services, contact and work with your Case Manager and he/she will help you.

- **Case Management is a stand alone service. A participant [or guardian, if applicable] may choose any case manager and cannot be expected or required to receive any other service from that provider.**

- **What happens after a choose a case manager?**

1. Your case manager will interview you and complete a level of care form to evaluate if your child would meet the criteria of institutional care.
2. This level of care form will be sent to the Division for potential eligibility assessment. If you are potentially eligible, your case manager will assist you in gathering the required information and scheduling the required assessments
3. If your child has a disability that may qualify as a related condition, see p. 6, the case manager will assist you in gathering medical documentation of that disability. This will be given to the psychologist for a more complete assessment and will be sent to the Division.
4. If you meet the criteria for the ICF/MR level of care, then a psychological evaluation is required when applying for the Child Waiver. This evaluation is done to obtain a diagnosis, which is needed for eligibility. A licensed psychologist of your choice will administer a series of tests to determine this score. The Case Manager will help you set up an appointment.
5. The Inventory for Client and Agency Planning (ICAP) is an assessment that is also required when applying for the Child Waiver. The Inventory for Client and Agency Planning (ICAP) is a 16-page booklet that assesses adaptive (things you do well) and maladaptive (inadequate) behaviors. It also gathers additional information to determine the type and amount of special assistance that you may need. The Inventory for Client and Agency Planning (ICAP) assessment includes an interview process that will include people who know the applicant well. The Case Manager is for working with you to identify friends, family members and/or teachers who know you/your child well, can give current information and are willing to be interviewed.

   Your case manager should also be helping you using Targeted Case Management services. These services include:
   1. Assist you in getting necessary documentation, such as medical records, psychological assessments, etc. to enable DDD to determine eligibility.
   2. Working with you and/or service providers to secure access to services.
   3. Helping you make arrangements for initial appointments for individuals with service providers and informing individuals of services available.

4. Advocate for individuals for the purpose of accessing needed services.
5. Crisis intervention and stabilization are provided in situations requiring immediate attention/resolution.
6. Assist you with linking to other available resources

ELIGIBILITY

- **What happens if I am eligible for services?**

1. You will receive a letter from Developmental Disabilities Division stating you are clinically eligible for services and whether or not funding is available.
2. If funding is not available you will be placed on a waiting list.
3. When funding becomes available you and your Case Manager will receive a funding letter. This letter will indicate what your Individually Budgeted Amount (IBA) will be. The Developmental Disabilities Division does not determine financial eligibility; the Department of Family Services determines this.
4. Your Case Manager will work with you or your family to make an appointment with the Department of Family Services (DFS) for financial eligibility. A copy of the funding letter and the Level of Care must be submitted to Department of Family Services during this appointment.
5. You can **NOT** receive services until you meet both clinical and financial eligibility and funding is available.
6. Once your child has an approved plan of care, your child will also be eligible for Medicaid coverage, if he/she is not already on Medicaid.

- **What happens if I meet both clinical and financial eligibility and funding is available?**

1. You will need to meet with the Area Resource Specialist to complete the initial IPC meeting training.
2. You will need to interview potential providers for availability and compatibility (a list of providers will be given to you by your Case Manager).
3. A team meeting will be scheduled by you, your Case Manager, Area Resource Specialist, and team to develop your plan of care.

- **What happens if I meet clinical eligibility, funding is not available, and I am put on a waiting list?**

If you are eligible for services but funding is not available your case manager should continue to provide Targeted Case Management services for you during the time you are on the waiting list. These services include:

1. Advocate for individuals for the purpose of accessing needed services.
2. Crisis intervention and stabilization are provided in situations requiring immediate attention/resolution.
3. Assist with linking you to other available resources

There is no set timeframe for available funding. If you have questions about where you are on the waiting list, call the Child Waiver Manager in the Cheyenne office.

- **What happens if I am not eligible for services?**

1. The Developmental Disabilities Division will make the final determination of whether or not an applicant is clinically eligible. The Developmental Disabilities Division is the only entity that can determine clinical eligibility.
2. The Developmental Disabilities Division will notify you in writing if you do not meet eligibility. A copy of this letter will be sent to your Case Manager.
3. Wyoming Medicaid Rules state that if you disagree with this denial, you may request an administrative hearing from the Wyoming Department of Health, Developmental Disabilities Division. Your request must be in writing and must identify with the reasons for your request and the issues to be raised at the hearing. The written request must be submitted within 30 days of the date of this denial and must be typed or legibly printed and signed. You may have an attorney, a relative, a friend, or other spokesperson, including yourself, represent you at this hearing.

- **What happens if I am turning 21?**

Six months before you turn 21 you will call your local Area Resource Specialist and they will help you apply for the Adult or ABI Waiver program.

- **What services are available?**

DESCRIPTIONS OF CHILD WAIVER SERVICES

TARGETED CASE MANAGEMENT: A service that allows case managers to get paid for the time that they spend working with a new applicant or a person on the waiting list. A case manager can assist the individual to get necessary documentation, such as medical records, psychological assessments, etc. to enable DDD to determine eligibility. Case Managers can work with individuals and/or service providers to secure access to services. They can contact individuals or others to ensure a participant is following a prescribed service plan and monitoring the progress and impact of that plan. Case Managers can also help make arrangements for initial appointments for individuals with service providers, informing individuals of services available. They can be an advocate for individuals for the purpose of accessing needed services. Crisis intervention and stabilization are provided in situations requiring immediate attention/resolution. The case manager cannot provider any direct service such as driving you to appointments during Targeted Case Management.

CASE MANAGEMENT: Services that will assist waiver recipients in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational and other services, regardless of the funding sources for the services to which access is gained. Case managers are responsible for the development of the Individual Plan of Care (IPC) through the Individual Plan of Care Team process, and the ongoing monitoring and documentation of the provision of services included in the individual's plan of care. **Case Management is required on a monthly basis** for all plans of care with one hour of direct contact at a minimum. Additionally, the case manager shall initiate and oversee the process of assessment and reassessments of the individual's level of care and the review of the plans of care at such intervals as are specified. **Monthly contact by the Case Manager shall be made with the participant where the participant lives.**

RESIDENTIAL HABILITATION TRAINER: An individualized array of training designed to allow individuals with developmental disabilities to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully with their parents, guardians, or in their own apartment. A certified Residential Habilitation Trainer provides **client specific, individually designed and coordinated sets of interventions** in the participant's home and community. The participant receives skills training to increase independence related to his or her own health care, self-care, home environment, comfort and safety and access and use of community services. Training is designed to address functional deficits in self-help, daily living skills, mobility, learning, communications, survival skills, reduction of maladaptive behaviors, community access and other necessary skills. The Residential Habilitation Trainer can only provide training to one individual at a time.

RESIDENTIAL HABILITATION: An individualized array of training, assistance and support services designed to allow individuals from 18 through 20 years of age to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully in a community integrated setting such as a group home. An individual must need 24 hour supervision and must meet targeting criteria before this service can be part of the plan. Residential Habilitation includes training and/or assistance to address functional deficits in self-help, daily living skills, mobility, learning, communications, survival skills, etc.

SPECIAL FAMILY HABILITATION HOME: An individualized array of training, assistance and support services designed to allow individuals to acquire, retain and improve self-help, socialization and adaptive skills necessary to reside successfully in a community integrated setting such as a family home. A SFHH is the primary residence of the child and the SFHH is the primary caregiver of the person served.
The Special Family Habilitation Home provider provides a client specific, individually designed and coordinated set of interventions and on-site assistance. Special Family Habilitation Home services include training and/or assistance to address functional deficits in self-help, daily living skills, mobility, learning, communications, survival skills, reduction of maladaptive behaviors, community access and other necessary skills. The Special Family Habilitation Home **also provides direct supports** such as assisting the person with activities of daily living, personal hygiene, dressing, eating, transfer or mobility needs and assisting with self-administered medication. The Special Family Habilitation Home assures access to necessary health care services. Provision of adequate levels of continuous supervision is also a responsibility of the Special Family Habilitation Home. Special Family Habilitation Home rates do not include the cost of room and board.

RESPITE CARE: Respite care consists of those services given to persons served unable to care for themselves. Respite is intended to give short-term relief for the primary care giver and is <u>not intended to be used when the primary caregiver is at work</u>. Respite must be episodic, for special events when the caregiver needs relief. It <u>cannot be used for daily scheduled supervision</u>. Respite services shall be limited to 7280 units per year (an average of 35 hours a week) per recipient unless otherwise pre-approved by the Division.

PERSONAL CARE: services may include tasks that need to be accomplished through hands on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care can include Activities of Daily Living (ADLS) and Instrumental Activities of Daily Living (IADLS). ADLS include bathing, dressing, toileting, transferring, positioning, maintaining continence, other hygiene tasks, eating, etc. IADLS include more complex life activities, such as personal hygiene, light housework, laundry, meal preparation, exclusive of cost of meal, transportation, grocery shopping, using the telephone medication and money management. Personal care is a one-to-one service than can be provided to participants needing assistance with the personal care tasks and are ***not receiving training to complete the task for themselves***. . A Circle of Support will be developed by the participant's team for all participants who live independently with monitoring or support and receive personal care services. Personal Care services shall be limited to 7280 units per year (an average of 35 hours a week) per recipient unless otherwise pre-approved by the Division.

HOMEMAKER: Services consisting of general household activities such as meal preparation and routine household care, which are provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. This service **does not** include direct care/supervision of the client. ***Homemaker services shall be limited to 3 hours per week per recipient unless otherwise pre-approved by the Division.*** Homemakers shall meet such standards of education and training as are established by the state. Homemaker services are not to be provided in Residential Habilitation settings.

ENVIRONMENTAL MODIFICATIONS (NEW & Repair): Environmental modifications are those physical adaptations to the home, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the recipient would require institutionalization. The environmental modification must have a specific purpose that provides accessibility, welfare, and safety for the waiver recipient.
Such adaptations may include:

- Installation of ramps
- Installation of grab-bars
- Widening of doorways
- Modification or addition of bathroom facilities to make them accessible
- Installation of specialized electrical and plumbing systems to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual

SKILLED NURSING: Services listed in the individual's plan of care that are ***prescribed by a physician****,* that are within the scope of the State of Wyoming's Nurse Practice Act may be provided by provider agencies and independent nurses as long as they meet the provider qualifications. The Wyoming Medicaid State Plan requires that skilled nursing services be provided by home health agencies that provide a minimum of two medically necessary services.

SPECIALIZED EQUIPMENT AND SUPPLIES (NEW & REPAIR): Specialized equipment includes devices, controls or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the State Medicaid Plan. In addition, these items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Medicaid Plan. Items purchased with waiver funds shall not be utilized for the purpose of recreational, leisure, entertainment or other purposes. Items purchased with waiver funds are intended to maintain or increase skills necessary to prevent institutionalization.

DIETITIAN SERVICES: Services provided by a registered dietitian include meal planning, consultation with and training for caregivers, and education for the individual served. This service does not include the cost of meals.

ROLES AND RESPONSIBILITIES

Below is a summary of the roles and responsibilities for guardians, participants, case managers, and providers. A participant, guardian and provider should review these responsibilities carefully. If there are any questions about them, the local Area Resource Specialist can be contacted.

Participants/Guardian Responsibilities

- Assist in providing evidence of the need for services and supports
- Assist in collecting necessary data and documentation, including school records, medical records, and social security information
- Assure that all providers are given necessary medical information, emergency information, contact information, and training
- Choose among providers and services and to have choices respected
- Participate in the program planning process, including participating in the development and review of the plan of care. **This includes cooperating with the case manager to schedule IPC meetings at least 30 days in advance of the meeting date.**
- Monitor service usage to adequately budget services for the entire plan year.
- Each year, make an appointment with the Department of Family Services to do the annual eligibility review
- Learn about rights and restrictions and be an active participant in any discussion about possible rights restrictions
- Abide by all rules, laws, and expectations of the community
- Take care of personal property and protect it from theft or loss
- Ask any questions about direct responsibilities if information or directions are not understood
- **Be available (with the participant at home) for the monthly home visits required by the case manager, canceling in an appropriate amount of time so as not to disrupt service.**
- Inform the case manager and/or providers of any concerns or questions, and to give them an opportunity to address any concerns or questions
- Inform case manager of any requested changes in services and follow the Division's transition procedures when changing service providers or moving to another location in the state. This includes scheduling the transition meeting two weeks in advance and allowing one week for the modification to be approved before the services are actually changed or the move takes place
- A guardian of a participant, will provide information to the courts at least twice a year or as required by the courts
- When applicable to review and verify documentation of services provided
- Review the plan of care and make sure it reflects the services and supports that are required and agreed upon
- Notify the Division of changes in residence, phone, guardianship, custody, etc
- Provide the case manager or providers with information in a timely manner on incidents, medication concerns, behavioral concerns, and other important information
- Assist in developing personalized schedule and training objectives
- Attend DD Division training sessions when ever possible

Case Manager Responsibilities

- Assist the team in determining which services are priorities
- Support choices and preferences unless doing so is illegal or clearly not in the best interests of the participant
- Provide the participant/guardian with informed choice regarding current service providers, including other case managers
- Assist the team in developing the individualized plan of care that includes the needs, interests, identified risks, and goals of the participant
- Review the plan of care with the participant and team in a manner that is easy to understand
- Work with providers if necessary, to develop a personalized schedule and training objectives.
- Give copies of the individual plan of care to providers in accordance with applicable privacy and confidentiality law and regulation
- Monitor services and billings by providers on the plan of care
- Be available to and at the times and places that are convenient for the participant, and to provide emergency contact information
- Complete a home visit each month, which is required to bill for case management services. The participant must be in the home at the time of the visit.
- Visit other service settings periodically to monitor the services on the plan of care
- Provide the Division and other agencies or providers with information in a timely manner on incidents, medication concerns, behavioral concerns and other important information
- Responsible for knowing and sharing current participant specific information; i.e. change in medications, behavioral changes, etc.
- Responsible for knowing current Division updates and training
- Recognize a possible conflict of interest and address it with the participant and/or guardian. Conflict of interest is defined in this book on page 15 and in the Plan of Care.
- Monitor service usage monthly so the participant can adequately budget services for the entire plan year.

Provider Responsibilities

- Participate in team meetings and provide pertinent information that allows the team to make the right decisions about services and supports
- Develop schedules and/or training objectives if the service requires such. These schedules and/or training objectives should reflect wants and desires of the participant as listed in the “About Me” section of the plan of care. The case manager and participant/guardian can assist in this.
- Provide the participant/guardian and the case manager with information in a timely manner on incidents, medication concerns, behavioral concerns, billing documentation, and other important information
- Use the team process to determine if changes need to be made to services on the plan of care, including changes to medications, behavior plans, meal time plans, identified risks, or any other significant changes that impact the services on the plan of care
- Follow the Division’s transition procedure to facilitate transitions prior to accepting participants into services or agreeing to serve them.
- Respect the participant’s rights and assure that all staff understand and respect the rights of the participant
- Notify the Division of any changes in address, phone or email immediately to alleviate any chance of deactivation or disruption of payment
- **Do not provide services until a copy of the pre-approval for the plan of care which includes all appropriate signatures is received**
- A copy of monthly documentation must be sent to the appropriate case manager by the 10th business day of the calendar month
- Keep accurate records of units, including the number of units used in the plan of care, and notify the case manager if unit usage is changing
- Responsible for knowing current Division updates and training
- Allow case managers to observe and monitor the services on the plan of care by periodically observing the direct delivery of services.
- Assist in developing a personalized schedule and training objectives for the participant

GLOSSARY

Area Resource Specialist (ARS): These specialists are geographically located throughout the State of Wyoming to provide local contact and support to families and person with developmental disabilities in Wyoming communities.

Case Manager: A service provider who helps an eligible person with a developmental disability to identify, select, obtain, coordinate and use both paid services and natural supports which enhance independence, productivity and integration consistent with her or his capacity and preferences.

Circle of Support: specific persons an individual can contact for help. These may include family members, friends, neighbors, taxi, bus, advocate, providers, landlord, community members or agencies, or local emergency agencies.

Conflict of Interest: specific to the plan of care, a conflict of interest is a situation in which a case manager has competing or conflicting interests or loyalties. Examples include:

- A self-employed case manager also provides other services on that participant's plan of care.
- An organization employs a participant's case manager, and also provides other services on the participant's plan of care.

Department of Family Services: This state agency processes the financial eligibility when you are applying for Developmental Disabilities waiver programs.

Developmental Disabilities: Mental, physical or behavior disability which occurs before the age of 22 and is likely to continue indefinitely.

Eligible: A person is qualified to gain Home and Community Based Waiver Services.

Individually Budgeted Amount: The Developmental Disabilities Division's distribution of funding that may be available to a participant to meet his/her needs.

Individual Plan of Care (IPC): A written plan of care for a participant that describes the type and frequency of services to be provided to the participant regardless of the funding source and that identifies the provider or provider types that furnishes the described services.

Individual Plan of Care (IPC) Team: A group of persons, selected by the participant, who is knowledgeable about the person and qualified, collectively, to assist in developing an individual plan of care for that person. Membership of the team shall include the participant, the guardian if applicable, the individually-selected service coordinator, providers on the person's individual plan of care, an advocate if applicable and any other person chosen by the participant.

Inventory for Client and Agency Planning (ICAP): One instrument used by the Developmental Disabilities Division to help determine eligibility and to determine the needs of the participant, available from Riverside Publishing.

Psychological Evaluation: A process that evaluates the mental capabilities of a person.

Related Condition: A condition that results in a severe, chronic disability affecting an individual which manifests itself before he or she reaches age twenty-two and that is attributable to cerebral palsy, seizure disorder, or any condition other than mental illness that is closely related to mental retardation and that requires similar services, as determined by a licensed psychologist or physician.

Services: Medical, habilitation or other services, equipment, or supplies, appropriate to meet the needs of a participant.

Targeted Case Management: A service that allows case managers to get paid for the time that they spend working with a new applicant and individuals on the waiting list. A case manager can assist the individual to get necessary documentation, such as medical records, psychological assessments, etc. to enable DDD to determine eligibility. Case Managers can work with individuals and/or service providers to secure access to services. They can contact individuals or others to ensure a participant is following a prescribed service plan and monitoring the progress and impact of that plan. Case Managers can also help make arrangements for initial appointments for individuals with service providers, informing individuals of services available. They can be an advocate for individuals for the purpose of accessing needed services. Crisis intervention and stabilization are provided in situations requiring immediate attention/resolution.

Waiting List: A list of persons who are eligible for covered services and who have submitted a completed application, but the services are unavailable because of limits imposed by funding for or on the waiver.

Waive: To allow services.

RESOURCES

WIND Family Support Network (WFSN)
Phone: (800 567-9376 or (307) 632-0839
Fax: (307) 632-0838
Website: http://wind.uwyo.edu./wfsn/
Email: carlawfsn@aol.com

The Arc of Wyoming Chapter (Arc)
Laramie County: (307) 632-1209
Natrona County: (307) 577-4913
Uinta/Lincoln County: (307) 789-7679
Sheridan County: (307) 672-8665
Lander/Riverton: (307) 335-8801

The Assistive Technology Resource Center
Phone: (800) 861-4312 or (307) 766-2084
Fax: (307) 721-2084

Department of Family Services
Available in each county
Can use the phone book for local listings
Or access the website at http://dfsweb.state.wy.us/index.html
Local phone numbers and contact information are listed under Districts

Governor's Planning Council on Developmental Disabilities
Phone: (800) 438-5191 or (307) 777-7230
Fax: (307) 777-5960
Website: http://ddcouncil.state.wy.us

People First of Wyoming
Phone: (307) 632-8855 or (800) 4385791
Fax: (307) 777-5960
Website: http://ddcouncil.state.wy.us

Protection and Advocacy Systems, Inc. (P&A)
Phone: (307) 632-3496
1-800-624-6748
Website: http://wypanda.vcn.com

Wyoming Guardianship Corporation (WGC)
Phone: (307) 635-8422
Fax: (307) 635-0776
Representative Payee: (307) 638-7097

Social Security Administration (SSA)
5353 Yellowstone Road, Room 210
Cheyenne, WY 82009
Phone: (307) 772-2135 Voice
Phone: (307) 772-1213 National
Phone: (307) 362-4634 Rock Springs
Web site: www.ssa.gov

Vocational Rehabilitation Division (DVR)
122 West 25th Street
Herschler Building, First Floor East
Cheyenne, WY 82002
Phone: (307) 777-7386
Fax: (307) 777-5939

Wyoming Services for Independent Living (WSIL)
190 Custer Street
Lander, WY 82520
Phone: (307) 332-4889 or (800) 266-3061
Fax: (307) 332-2491

Wyoming Independent Living Rehabilitation, Inc. (WILR)
305 West 1st Street
Casper, WY 82601
Voice/TDD: (307) 266-6956 or (800) 735-8322
Fax: (307) 266-6957

Wyoming Independent Living Rehabilitation, Inc. (WILR)
1616 E 11th Street
Cheyenne, WY 82009
(307) 637-5127

Visually Impaired Program (VIP)
Hathaway Building; Room 129
Cheyenne, WY 82002
Phone: (307) 777-6257
Email: golson@educ.state.wy.us

Department of Health, Substance Abuse Division
6101 Yellowstone Road; Suite 220
Cheyenne, WY 82002
Phone: (307) 777-6494 or (800) 535-4006
Fax: (307) 777-7006
Website: http://wdh.state.wy.us

Department of Health, Aging Division
6101 Yellowstone Road; Suite 259 B North Building
Cheyenne, WY 82002
Phone: (307) 777-7995
Fax: (307) 777-5340
Website: http://wdh.state.wy.us

Department of Health, Mental Health Division
6101 Yellowstone Road; Suite 220
Cheyenne, WY 82002
Phone: (307) 777-7094
Fax: (307) 777-5580
Website: http://wdh.state.wy.us

Veterans Affairs Commission
5905 CY Avenue
Casper, WY 82604
Phone: (307) 265-7372 or (800) 833-5987
Fax: (307) 265-7392
National website: http://www.va.gov

Shoshone & Arapaho Social Service
Wind River Indian Agency
Fort Washakie, WY 82514
Phone: (307) 332-4586

UPLIFT
4007 Greenway Street, Suite 201
Cheyenne, WY 82001
1-888-uplift3
Website: www.upliftwy.org

Parent Information Center
5 North Lobban Ave.
Buffalo, WY 82834
1-800-660-9742
Website: www.wpic.org

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